FRAMEWORK FOR ANNUAL REPORT OF STATE CHILDREN'S HEALTH INSURANCE PLANS UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

Preamble

Section 2108(a) of the Act provides that the State must assess the operation of the State child health plan in each fiscal year, and report to the Secretary, by January 1 following the end of the fiscal year, on the results of the assessment. In addition, this section of the Act provides that the State must assess the progress made in reducing the number of uncovered, low-income children.

To assist states in complying with the statute, the National Academy for State Health Policy (NASHP), with funding from the David and Lucile Packard Foundation, has coordinated an effort with states to develop a framework for the Title XXI annual reports.

The framework is designed to:

- Recognize the ***diversity*** of State approaches to SCHIP and allow States ***flexibility*** to highlight key accomplishments and progress of their SCHIP programs, **AND**
- Provide ***consistency*** across States in the structure, content, and format of the report, **AND**
- Build on data ***already collected*** by HCFA quarterly enrollment and expenditure reports, **AND**
- Enhance ***accessibility*** of information to stakeholders on the achievements under Title XXI.

FRAMEWORK FOR ANNUAL REPORT
OF STATE CHILDREN'S HEALTH INSURANCE PLANS
UNDER TITLE XXI OF THE SOCIAL SECURITY ACT

State/Territory: Connecticut
(Name of State/Territory)

The following Annual Report is submitted in compliance with Title XXI of the Social Security Act (Section 2108(a)).

Department of Social Services, Patricia Wilson-Coker, Commissioner

SCHIP Program Name (s) HUSKY Program
SCHIP Program Type ____ Medicaid SCHIP Expansion Only
____ Separate SCHIP Program Only
X Combination of the above

Reporting Period **Federal Fiscal Year 2000 (10/1/99-9/30/00)**

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Submission Date 03-16-01

SECTION 1. DESCRIPTION OF PROGRAM CHANGES AND PROGRESS

This sections has been designed to allow you to report on your SCHIP program=s changes and progress during Federal fiscal year 2000 (September 30, 1999 to October 1, 2000).

1.1 Please explain changes your State has made in your SCHIP program since September 30, 1999 in the following areas and explain the reason(s) the changes were implemented.

Note: If no new policies or procedures have been implemented since September 30, 1999, please enter ›NC= for no change. If you explored the possibility of changing/implementing a new or different policy or procedure but did not, please explain the reason(s) for that decision as well.

Program eligibility

Rules for municipal employees changed allowing municipal employees with insurance to qualify for HUSKY B, if they drop insurance due to extreme economic hardship. Census income for temporary census employees was also changed to be disregarded from determining eligibility.

Enrollment process **No Change**.

Presumptive eligibility

Presumptive eligibility for Medicaid was implemented effective Oct.1, 2000.

Continuous eligibility **No Change**

Outreach /marketing campaigns

School Lunch Program--The Department of Social Services/HUSKY Plan collaborated with the Department of Education and local school districts to incorporate Medicaid/SCHIP information in the application for Free or Reduced Price Meals or Free Milk, generally known as the "school lunch program." Local school districts included an addendum to the school lunch program application to give parents information about the availability of free - or low-cost health coverage. The addendum offered a check-off box to request information, as well as the HUSKY Plan's toll-free number and website address. While linkage with the school lunch program began in 1999 in the form of distribution of bilingual flyers, this was the first time HUSKY information was included with the actual application. Although local school district participation was optional, at least 4,000 forms were forwarded to the HUSKY enrollment contractor for follow-up as a result of this initiative. Additional information requests were generated by inclusion of the toll-free number and the website address.

Coaches' Campaign--HUSKY began a partnership with the Connecticut Interscholastic Athletic Association, CIAC, to expand a Coaches' Campaign for HUSKY Healthcare. The campaign began at a regional level with a HUSKY outreach contractor ,Thames Valley Council for Community Action, New London, and an advertising firm, the Ad Agency, Norwich, joining in a communications project with local school systems. The Department of Social Services established a partnership with CIAC to expand the campaign. The communications materials were developed for a broader audience, and information kits featuring two sets of pamphlets, different covers featuring boys and girls, were prepared for 12 school systems. The schools were selected by CIAC to represent a range of size and demographic makeup. As Connecticut prepares a second printing for broader distribution, the state of New Jersey has been given permission to use the pamphlet format for a similar Coaches' Campaign.

TV Ad--the first paid TV commercial for the HUSKY Plan aired in mid-2000 on the Connecticut Fox affiliate, WTIC-TV/Hartford. The 30-second spot featured Governor John G. Rowland speaking about the benefits of HUSKY health care at a child care center in Hartford. Surrounding the Governor are children at the center and high school students who participate as HUSKY outreach volunteers as part of their health education studies. Brief testimonial soundbytes from two parents of HUSKY members are also featured. The Department of Social Services is currently working with Connecticut movie theater

owners to place the ad in preview trailer packages, and is considering further TV placement, depending on available funding.

Connecticut Community Healthcare Initiative (CCHI)--A major change in community funding for HUSKY public outreach was initiated in the summer of 2000 with the Department of Social Services' issuance of a request-for-proposals for CCHI. This $4 million initiative is intended to combine HUSKY outreach with the Healthy Start program for case management with prenatal care for pregnant women and/or women with children up to age three. As the federal fiscal year ended, Ocotber, 2000, DSS was evaluating proposals for 15 "supercontracts" to cover geographical service areas aligned with DSS regional and subregional offices. The change to an integrated health care outreach approach marks an evolution from the first round of mostly smaller community-based HUSKY outreach contracts. The initiative will provide community outreach, education and application assistance services throughout the state. Priority target areas include schools, community/health organizations, employers that do not provide dependent care benefits, and religious organizations.

Eligibility determination process **No Change**

Eligibility redetermination process **No Change**

Cost-sharing policies **No Change**

Benefit structure and cost sharing policies for Behavioral Health Benefits changed due to Connecticut statutory changes to the Mental Health Parity provisions. Behavioral health cost sharing was brought in line with that of medical services. See attached State Plan Amendment. Connecticut implemented the exclusion of Native Americans and Alaskan Natives enrolled in the separate SCHIP program (HUSKY B) from cost sharing requirements due to HCFA directive. See attached State Plan Amendment.

9. Crowd-out policies **No Change**

11. Delivery system

Kaiser Permanente, a HUSKY A and B managed care provider, terminated its contract as of 9/30/00. Members were transitioned into the remaining health plans.

12. Coordination with other programs (especially private insurance and Medicaid) See Response to Section 2, Question 2.6.

13. Screen and enroll process **No Change**

14. Application

New application / renewal form designed for use in the HUSKY program effective 9/2000.

15. Other

1.2 **Please report how much progress has been made during FFY 2000 in reducing the number of uncovered, low-income children.**

Please report the changes that have occurred to the number or rate of uninsured, low-income children in your State during FFY 2000. Describe the data source and method used to derive this information.

We do not have recent census data by which to measure the progress made in the number of uninsured children during this period. However, based on the number of additional children enrolled

into the HUSKY program during FFY 2000, we can infer that Connecticut has a net increase of 5,288 children enrolled in HUSKY A & B. Data source: Medicaid and SCHIP enrollment reports.

2. How many children have been enrolled in Medicaid as a result of SCHIP outreach activities and enrollment simplification? Describe the data source and method used to derive this information.

The net increase in Medicaid enrollment of children under 19 years of age, between FFY 99 and FFY 2000, was 2,594. Connecticut uses a combined application for both SCHIP and Medicaid. Additionally the HUSKY outreach strategy targets children globally and does not make a distinction between the two programs. Growth in HUSKY enrollment can be attributed to multiple factors, namely: 12 months of continuous eligibility, increased income limits for older children, and HUSKY outreach efforts. It is difficult to discern which portion of the growth can be discretely apportioned to outreach.

3. Please present any other evidence of progress toward reducing the number of uninsured, low-income children in your State.

The CPS estimate of uninsured Connecticut children with incomes at or below 200 percent of the federal poverty level shows a decline from 57,000 in 1996-1998 to 53,000 in 1997-1999. The CPS data for the time period covered by this report is unavailable. However, with the increase in HUSKY A and HUSKY B enrollment in FY 2000, the number of uninsured children is assumed to have dropped by 5,288 (2,694 HUSKY B, 2,594 HUSKY A).

4. Has your State changed its baseline of uncovered, low-income children from the number reported in your March 2000 Evaluation?

__X__ No, skip to 1.3

____ Yes, what is the new baseline?

What was the justification for adopting a different methodology?

What is the State's assessment of the reliability of the estimate? What are the limitations of the data or estimation methodology? (Please provide a numerical range or confidence intervals if available.)

1.3 Complete Table 1.3 to show what progress has been made during FFY 2000 toward achieving your State's strategic objectives and performance goals (as specified in your State Plan).

In Table 1.3, summarize your State's strategic objectives, performance goals, performance measures and progress towards meeting goals, as specified in your SCHIP State Plan. Be as specific and detailed as possible. Use additional pages as necessary. The table should be completed as follows:

Column 1: List your State's strategic objectives for your SCHIP program, as specified in your State Plan.

Column 2: List the performance goals for each strategic objective. Column 3: For each performance goal, indicate how performance is being measured, and progress towards meeting the goal. Specify data sources, methodology, and specific measurement approaches (e.g., numerator, denominator). Please attach additional narrative if necessary.

.Note: *If no new data are available or no new studies have been conducted since what was reported in the March 2000 Evaluation, please complete columns 1 and 2 and enter ANC@ (for no change) in column 3.*

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
OBJECTIVES RELATED TO REDUCING THE NUMBER OF UNINSURED CHILDREN		
9.1.1 To increase the number of children in Connecticut with health insurance by expanding Medicaid (HUSKY Part A) coverage and creating a new health insurance program for previously uninsured children, to be know as HUSKY Part B. **9.1.2** To maximize participation in HUSKY, Parts A and B through outreach, single point of entry, presumptive eligibility, a simplified application process and annual enrollment.	**9.2.1**To increase the number of children covered by health insurance. **9.2.2** To maximize participation in HUSKY Parts A and B.	Data Sources: The data source for enrollment in HUSKY A (Medicaid) is Connecticut's Eligibility Management System (EMS). The data source of enrollment in HUSKY B is Benova's BESSTB system Methodology: Enrollment growth Progress Summary: For FFY 2000, we have an unduplicated count of Medicaid expansion of 9,211 children enrolled. Data Sources: The data source for enrollment in HUSKY A (Medicaid) is Connecticut's Eligibility Management System (EMS). The data source of enrollment in HUSKY B is Benova's BESSTB system. Application activity data source is Benova's BESSTB system. Methodology. Count of applications received. Progress Summary: **Outreach—**The HUSKY Healthcare Outreach Partnership. The Department of Social Services (Department) is continuing a multi-level public outreach campaign to inform parents about the availability of children's health coverage, in collaboration with the Connecticut Children's Health Council and Project, Benova (eligibility and enrollment contractor), Infoline, state Medicaid Managed Care Council and other partners in the health and human services field. An initial DSS community-based outreach contracting initiative is transitioning to an integrated HUSKY outreach and Healthy Start prenatal care case management initiative,

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		providing $4 million in funding to 15 contractor agencies statewide. This program complements HUSKY outreach and education in the Covering Connecticut's Kids initiative, funded by the Robert Wood Johnson Foundation and coordinated by the Children's Health Council. In the first 30 months of Connecticut's combined Medicaid/SCHIP program, more than 60,900 applications to the single point of entry servicer (Benova) have been generated by a wide variety of outreach measures. Many additional applications have been received at DSS field offices. The HUSKY Plus Behavioral and HUSKY Plus Physical Centers have actively engaged in outreach within the community, as well as the managed care organizations. The DSS HUSKY Outreach Team, with outreach and education partners, conducted outreach to school health and school lunch personnel; athletic coaches in a pilot project with the CT Interscholastic Athletic Association; through community-technical colleges; through employers such as nursing facilities and home care agencies; with the Department of Labor rapid-response team for employees being laid off; through select media outlets, particularly those serving minority communities; through a grant to the CT chapter of the American Academy of Pediatrics to reach selected medical practices; and myriad other outreach activities and partnerships. **Single Point of Entry (SPES)—**a single point of entry server, known as Benova, processes eligibility and enrollment. Benova also participates in outreach. **Presumptive Eligibility—**Implementation at school and community centers began on 10/1/00. The plan is to include Head Start and WIC centers in the near future. As of 12/31/00, 239 children have been enrolled through presumptive eligibility efforts at school and community centers. This number is expected to increase as an additional 10 – 15 school-based and community-based centers are brought on board by the end of January 2001. **Simplified Application Process—**Information and application forms are available

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		through Infoline. Benova is able to accept an application by telephone, print it, and send it to the applicant for verification of income and signature. Both Benova and Infoline offer toll-free telephone numbers. In addition, a 4-page application form has been developed and is available for use. **Annual Enrollment—** Using reports from Benova, The SPES, increases for HUSKY A & B are as follows: Net increase in HUSKY A from 10/99 to 09/00 is 2,594. Net increase in HUSKY B for the same time period is 2694, for a combined total 5,288.
OBJECTIVES RELATED TO SCHIP ENROLLMENT		
9.1.2 To maximize participation on HUSKY, Parts A and B through outreach, a single point of entry, presumptive eligibility, a simplified application process and annual enrollment.	**9.2.2** Increase the number of insured children 18 or under who are between 185% and 300% of the federal poverty level.	Data Sources: BESSTB and EMS enrollment files. Methodology: Unduplicated enrollment increase. Progress Summary: During FFY 2000, the unduplicated number of children enrolled in the SCHIP Medicaid expansion is 9,211. The unduplicated number enrolled in the separate SCHIP program is 10,714. For a total SCHIP unduplicated count of 19,925.
OBJECTIVES RELATED TO INCREASING MEDICAID ENROLLMENT		
9.1.2 To maximize participation in HUSKY Parts A and B through outreach, a single point of entry,	**9.2.2** 1. Expand Medicaid (HUSKY Part A) enrollment of uninsured children 15	Data Sources: EMS. Methodology: Unduplicated count of Medicaid Expansion recipients during FFY 2000.

Table 1.3		
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presumptive eligibility, a simplified application process and annual enrollment.	– 18 years old that are under 185% of the federal poverty level. 2. Expand Medicaid (HUSKY Part A) enrollment of uninsured children under 15 years old who are under 185% of the federal poverty level.	Progress Summary: During the reporting period, 9,211 children were enrolled in the HUSKY A expansion group. Data Sources: EMS. Methodology: Unduplicated count of Medicaid recipients under 19 who were not part of the expansion group. Progress Summary: The unduplicated count of Medicaid children (minus the expansion children) enrolled during FFY 2000 equals 222,234.
OBJECTIVES RELATED TO INCREASING ACCESS TO CARE (USUAL SOURCE OF CARE, UNMET NEED)		
Currently there are no strategic objectives related to access in the state plan.		Data Sources: Methodology: Progress Summary:
OBJECTIVES RELATED TO USE OF PREVENTIVE CARE (IMMUNIZATIONS, WELL-CHILD CARE)		
9.1.3 To promote the health of children through a health benefit package tailored to the health	**9.2.3** To promote the health of children through a comprehensive health benefits package.	**1. Immunizations:** **HUSKY A** Data Sources: Administrative reports, Encounter data

Table 1.3		
(1) Strategic Objectives (as specified in Title XXI State Plan and listed in your March Evaluation)	(2) Performance Goals for each Strategic Objective	(3) Performance Measures and Progress (Specify data sources, methodology, time period, etc.)
care needs of children, which includes comprehensive preventive services.	1. Match or exceed the statewide average of the percentage of children in HUSKY Parts A and B who receive immunizations by age two.	Methodology: HUSKY A and HEDIS modified. **See attached.** Progress Summary: During the reporting period, a total of 6,519 2-year olds met the continuous enrollment criteria. Of that total, 75.3% received all required immunizations. This represents a decrease of –1.7% from the last reporting period. The HUSKY A rate of immunization currently matches the New England regional average and substantially exceeds the national average (64.8%) for commercial managed care plans. The HUSKY A rate of immunization also exceeds the national average for Medicaid managed care plans (53%). **See attached.** **HUSKY B** Data Sources: Administrative reports from the Managed Care Organizations. Methodology: HUSKY A and HEDIS 1999 modified for HUSKY B. Progress Summary: During the reporting period of July 1999 – June 2000 a total of 34 members met the criteria to be included in the report. Twenty-four (70.59%) of eligible members were known to be up to date on immunizations. **See attached.** **2. Well-Child Visits:** **HUSKY A** Data Sources: Administrative reports and encounter data. Methodology: EPSDT Periodicity Schedule. In Connecticut, it is based on AAP and ACIP Guidelines. **See Attached.** Progress Summary: During the reporting period the total number of individuals

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		eligible for EPSDT was 214,654. Of this group, 180,361 were eligible to receive at least one initial or periodic screening service (Screening ratio = 65.15%). The total number of eligibles that actually received at least one initial or periodic screening service was 96,628 (Participation ratio = 51.36%). These figures represent a decrease of 3,527 eligibles served, as compared to the previous reporting year. The participation ratio likewise decreased (a total decrease of –8.80%) from the previous year. **See Attached.** **HUSKY B** Data Sources: Administrative, hybrid. Methodology: HUSKY A, HEDIS. Progress Summary: During the reporting period of July 1999 – June 2000, a total of 7,928 HUSKY B enrollees were eligible for well child visits. This represents an increase of 2850 eligible children from the last reporting period. The total percent of recommended well child visits received was 77.2% (screening ratio), which is an increase of 14.2% from the previous reporting year. The total percent of children receiving well child visits was 60.6% (participant ratio). This represents an increase of 4.6%. **See Attached.**

OTHER OBJECTIVES/ HUSKY PLUS		
9.1.4 To assist those children enrolled in HUSKY B who have special health care needs, to receive	**9.2.4** To assist children with special physical and behavioral needs through HUSKY Plus.	Data Sources: Administrative reports; medical records.

appropriate care through two supplemental plans (HUSKY Plus).	100% of referrals to HUSKY Plus to have eligibility determinations within 21 days. Track the percentages of referrals to HUSKY Plus accepted or denied. 100% of children with the following conditions will receive care according to individual needs and professional guidelines: 1. Cerebral Palsy 2. Cystic Fibrosis 3. 16Major Depression	Methodology: Two HUSKY Plus Data Collection Tools (1 administrative, 1 medical record audit), as adapted from the HUSKY Plus Medical Audit Form 2000. **See Attached.** Progress Summary: An aggregate total of 140 children were referred to HUSKY Plus Physical (120) and HUSKY Plus Behavioral (20) during the specified time period. Eligibility for HUSKY Plus was determined within 21 days for 127 of the referrals (93%). Eligibility determination exceeded 21 days for 9 (7%) children who were referred to HPB. Since the last reporting period, the rate of timely eligibility determination has improved (+14.60%) while the rate of late eligibility determinations has decreased (-15.60%). **See Attached Data Compilation Sheet.** 2. Data Sources: Same as above. Methodology: Same as above. Progress Summary: An aggregate total of 125 (92%) of those referred were accepted into the HUSKY Plus programs. This represents an aggregate increase of 79 children accepted into HUSKY Plus. HPP accepted 114 (91.2%) children, while HPB accepted 11 (64.7%) children and denied 6 children. **See Attached.** 3. Data Sources: Same as above. Methodology: Same as above. Progress Summary: A total of 16 (13%) of HUSKY Plus enrollees carried a diagnosis of cerebral palsy, cystic fibrosis, or major depression. In HPP there were two enrollees who were diagnosed with cystic fibrosis and 13 enrollees who were diagnosed with cerebral palsy. HPB had one enrollee who was diagnosed with major depression. **See Attached.**
9.1.5 To design the HUSKY Plus program	**9.2.5** To maximize coordination between	1. Data Sources: Same as above.

in a way that will maximize coordination between HUSKY B and HUSKY Plus, by integrating basic health care needs into the care provided for intensive health care needs and, whenever possible, building upon the existing therapeutic relationships with Title V providers.	HUSKY B and HUSKY Plus. 1. 100% of children in HUSKY Plus who receive case management. 2. 100% of children in HUSKY Plus, who were formerly covered by Title V, who will continue to have the same specialty provider.	Methodology: Same as above. Progress Summary: An aggregate total of 119 (95%) of children enrolled in HPP and HPB received case management services. HPB provided case management services to 9 (81.8%) enrolled children; HPP provided case management services to 109 (95.6%) enrolled children. The Lead Case Management Coordinator was identified for 108 (99%) HPP children and 9 (90%) HPB children, for an aggregate total of 117 (98.3%). This represents an aggregate improvement ratio of +5.1% from the previous reporting year. The HUSKY B representative who was assigned to the case management team was identified for 110 (96.5%) HPP children and 9 (81.8%) HPB children, for an aggregate total of 119 (95.2%). This represents an aggregate improvement ratio of +8.8% from the previous reporting period. Global Plan of Care (GPC): A GPC was completed for 87 (78%) HPB and HPP children within 30 days of eligibility determination for HUSKY Plus [HPP = 103/(90%) HPB = 9/(81.8%)]. This represents an aggregate improvement ratio of +5%. Reference was made to Individual Education Plans and Individual Family Service Plans for 91% of children with a completed GPC. Detailed information on specific services provided such as Birth to Three program, Early Learning Centers, Speech and Occupational therapies, etc. was consistently provided in the GPC. Progress notes referring to the GPC treatment goals were documented in 80% of the records with a GPC. **See Attached.** 2. Data Sources: Same as above. Methodology: Same as above. Progress Summary: In HPP six enrollees had previous Title V services. Of these, three (50%) continued to use the same specialty provider(s). **See Attached.**

1.4 If any performance goals have not been met, indicate the barriers or constraints to meeting them. NOT APPLICABLE

1.5 Discuss your State's progress in addressing any specific issues that your state agreed to assess in your State plan that are not included as strategic objectives.
NOT APPLICABLE

1.6 Discuss future performance measurement activities, including a projection of when additional data are likely to be available .

Connecticut will be conducting or completing reports on the following activities specific to the HUSKY B population:

External Quality Review of the HUSKY B Plans, estimated due 2/01.
External Quality Review Data Validation Audit of the HUSKY B Utilization Reports, due 4/01.
External Quality Review of the HUSKY Plus Programs, estimated due 3/01.
"Mystery Shopper" Audit of HUSKY Plans, estimated due 3/01 for HUSKY A, 12/01 for HUSKY B.
CAHPS Survey, 2001

Please attach any studies, analyses or other documents addressing outreach, enrollment, access, quality, utilization, costs, satisfaction, or other aspects of your SCHIP program's performance. Please list attachments here .

Please also refer to section 2.8 for a discussion of these activities.

HUSKY A
External Quality Review of the HUSKY A Plans
Utilization Reports
Special Reports

HUSKY B

Utilization Reports
Administrative Reports

HUSKY Plus

External Quality Review Corrective Action Plans

SECTION 2. AREAS OF SPECIAL INTEREST

This section has been designed to allow you to address topics of current interest to stakeholders, including; states, federal officials, and child advocates.

2.1 Family coverage:

1. If your State offers family coverage, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other program(s). Include in the narrative information about eligibility, enrollment and redetermination, cost sharing and crowd-out.

   Connecticut does not offer SCHIP family coverage however, Medicaid coverage was expanded, January 2001, to include relative caretakers with income levels up to150% FPL of children in Medicaid. The asset limit was also dropped as an eligibility criteria.

How many children and adults were ever enrolled in your SCHIP family coverage program during FFY 2000 (10/1/99 -9/30/00)?

Number of adults -0-
Number of children -0-

Connecticut does not have family coverage in SCHIP.

How do you monitor cost-effectiveness of family coverage?

Not Applicable

2.2 Employer-sponsored insurance buy-in:

If your State has a buy-in program, please provide a brief narrative about requirements for participation in this program and how this program is coordinated with other SCHIP program(s). **Not Applicable**

How many children and adults were ever enrolled in your SCHIP ESI buy-in program during FFY 2000?

Not Applicable

Number of adults -0-
Number of children -0-

2.3 Crowd-out:

How do you define crowd-out in your SCHIP program?

Connecticut defines crowd-out as a six-month waiting period before children who dropped employer-supported health care benefits can be enrolled into the SCHIP program (HUSKY B). There are several exceptions to this six-month waiting period, including self-employment, loss of employment, death of parent, and financial hardship (as defined as a family paying more than 10% of gross income on health insurance premiums).

How do you monitor and measure whether crowd-out is occurring?

Program reports include number of denials because children were either insured at time of application or dropped insurance within 6 months of applying for HUSKY B. There is no way to track the number of parents who did not apply because they believed their children would not qualify because they are currently insured.

Generally, crowd-out is a confusing area. It is difficult for some parents to understand that crowd-out does not apply if they are paying for health coverage on the private market. It also does not apply if a child will be eligible for Medicaid. So it is likely that some applications are deterred. Some parents are frustrated because their current employer-related coverage is expensive and offers limited benefits. They find themselves in a 'Catch-22' situation of not being able to access an extensive and affordable program like SCHIP/HUSKY B. They are essentially penalized for having a certain income and a certain health benefit, however limited. In this light, crowd-out accomplishes the goal of avoiding the supplantation of employer related insurance by SCHIP, but does not accomplish the goal of access to a full range of health

care for children.

What have been the results of your analyses? Please summarize and attach any available reports or other documentation.

During FFY 2000, 624 children were denied HUSKY B (separate SCHIP program) eligibility due to either having employer-sponsored insurance at the time of application (587) or having dropped it within 6 months of application (37).

Which anti-crowd-out policies have been most effective in discouraging the substitution of public coverage for private coverage in your SCHIP program? Describe the data source and method used to derive this information.

Six months of ineligibility for HUSKY B after dropping employer sponsored insurance coverage. Data Source: Benova application activity reports including denials because of existing insurance; clients not dropping insurance until hardship conditions are met.

2.4 Outreach

A. What activities have you found most effective in reaching low-income, uninsured children? How have you measured effectiveness?

As noted in the SCHIP evaluation report to HCFA by DSS on March 31, 2000, the crux of HUSKY outreach is a grassroots, community-based approach. We bring information directly to parents at community meetings, fairs, events and work site sessions., HUSKY outreach also brings the message to professionals who work with parents through a 'key informant' model. These are the known and trusted people in health, education, human services and other fields in the community who can vouch for the program and provide follow-up assistance.

Because HUSKY is a government-sponsored program, it is especially important that we access local community networks that already have the contacts and buy-in with parents. This helps cut through the stigma factor and provides on-scene application assistance to surmount such barriers as fears of immigrant parents about public charge (primarily a Medicaid eligibility barrier).

By the same token, the wide, higher-than-usual-income audience for SCHIP indicates the need for commercial-like information materials and outreach approaches. These potential clients are parents who may have never enrolled a family member in a government program. For HUSKY, the consolidated Medicaid and SCHIP potential client pool or target audience, the education and outreach measures range from printed brochures, flyers, information cards, posters and promotional items to radio advertisements, video presentations and a professionally-designed website with an email contact point. During FFY 2000, a TV advertisement, pilot billboards and transit advertising began.

A look at "how callers heard of HUSKY," as reported by Connecticut's principal call center, HUSKY Health Infoline, provides some measurement of effectiveness. For the period January-June 2000, by far, the highest number of calls were attributed to friend/family/word of mouth (1,485). This nebulous category of positive word-of-mouth continues to be the most successful outreach indicator, although it is probable that the work of many individual outreach activities may actually be reflected here. It does demonstrate that people vouching for HUSKY are our best ambassadors. Interestingly, the next call generator for that period was Letter 1-2000, a DSS initiative to reach out to parents of formerly-enrolled HUSKY A members (403). Additional call generation sources were: DSS itself (387); schools (353), with volume highest in autumn; flyer/brochure/poster' (316); newspaper/magazine/phonebook (306); doctor (388); clinic/hospital (274); DMV insert which referred people to HUSKY information in DMV registration renewal mailings; Television (196); and employer/temp agencies (174). There were 35 additional categories.

While there is definitely a large number of outreach measures prompting parents to call about HUSKY, we have also determined four priority target areas for contractors in the new Connecticut

Community Healthcare Initiative. Schools, employers that do not provide dependent benefits, community/health organizations, and faith communities. This determination was based on the experience since HUSKY kickoff in mid-1998 and the national literature. Contractors must focus on at least two of the priority target areas.

While Connecticut's approach to public outreach remains multi-faceted and multi-level, from community presentations to broadcast media, we are prioritizing certain areas for the local and regional outreach efforts. In addition, we are participating in the federal CompCare technical assistance initiative to build our capacity to track and evaluate contractor outreach activities, as well as, to develop a geographical and demographic trend analysis process for applications and enrollments. This initiative will help us with the particularly difficult challenge of evaluation of individual outreach activities.

This challenge is not only difficult because so many parents cite the catch-all category, "word-of-mouth" factor, but because of the uncertain definition of effectiveness itself. As noted in the 3/31/00 report:

> "With the growing recognition that application assistance needs to be an integral part of outreach for many parents, even the methodology of defining success can be elusive. For example, on one level an outreach activity might be judged successful if it sparks a telephone call to the consumer call center. However, if the parent does not follow up with completing an application, the end result is zero.
>
> **"On another level, outreach might be judged successful, if, an application assistance component, such as an outreach-affiliated local agency, is part of the outreach service and a completed application is smoothly filed. In this model, we could judge outreach successful by not only sparking a call to the hotline but by helping and encouraging the parent through the application and enrollment process—and being there to answer questions and advocate along the way."**

With the Connecticut Community Healthcare Initiative, DSS has affirmed the importance of community-based application assistance as a component of outreach, when indicated. One of our tasks is to help contractors strike a productive balance between outreach/education/marketing and an appropriate level of application assistance, rather than focusing on ''one-size-fits-all" application assistance at the expense of broader outreach efforts.

2. Have any of the outreach activities been more successful in reaching certain populations (e.g., minorities, immigrants and children living in rural areas)?

The emphasis on grass-roots, community-based outreach, as noted above, is acknowledged as especially important in reaching minority communities and newcomer/immigrant populations. This principle was evident in DSS's first round of community-based outreach funding (ended October 2000), is now being succeeded and expanded in the Connecticut Community Healthcare Initiative. The request-for-proposals and subsequent contracts are infused with the principles of consumer input and cultural competence. Contractors must conduct a consumer input process and demonstrate how the cultural competence will inform outreach and case management programs. Part of the intention is to ensure that diverse consumers of health care and health insurance advise and refine contractors' outreach messages and plans.

3. Which methods best reached which populations? How have you measured effectivness?

Because HUSKY does not yet have the resources to analyze enrollment trends by population group with respect to the outreach measure or measures to which the application can be attributed, information about relative effectiveness of specific measures is elusive. However, we can state that the consistency of community-based outreach, complemented by advertising on Spanish-language radio and in Spanish- and English-language publications serving diverse communities, has made an impact. As one indicator, the regional case report of HUSKY Health Infoline for July 1999-June 2000 finds highest numbers, by far, in urban areas. While this might be expected because there are more potential consumers in large and small cities, it also demonstrates that outreach does result in call-center cases from the most expected areas of relevant need. Bridgeport was first (898), followed by Hartford (876), New Haven (596), Stamford (500),

Waterbury (402), and Norwalk (352).

2.5 Retention:

What steps are your State taking to ensure that eligible children stay enrolled in Medicaid and SCHIP?

A Robert Woods Johnson Grant has been awarded to the HUSKY program for Supporting Families After Welfare Reform. The grant will be used to diagnose systems, procedures, and policy issues which can be contributing factors in eligible children losing HUSKY coverage. Changes have also been made to the information systems to ensure families who lose their TANF coverage correctly transition to either 1931 coverage or two-year medical transition coverage.

What special measures are being taken to reenroll children in SCHIP who disenroll, but are still eligible?

___ Follow-up by caseworkers/outreach workers
___ Renewal reminder notices to all families
__X__ Targeted mailing to selected populations, done in June and July, 2000, specify population Children < 19 years old who had lost eligibility due to procedural reasons.
___ Information campaigns
__X__ Simplification of re-enrollment process, please describe Form shortened from 8 pages to 4.
__X__ Surveys or focus groups with disenrollees to learn more about reasons for disenrollment, please describe Survey to be done as part of RWJ iniatiative during calendar year 2001.
___ Other, please explain

Are the same measures being used in Medicaid as well? If not, please describe the differences.

Yes.

Which measures have you found to be most effective at ensuring that eligible children stay enrolled?

Information System modifications that ensure that families continue to receive family coverage at the time of TANF closure.

What do you know about insurance coverage of those who disenroll or do not reenroll in SCHIP (e.g., how many obtain other public or private coverage, how many remain uninsured?) Describe the data source and method used to derive this information.

A survey commissioned by the Children's Health Council and conducted by the University of Connecticut's Center for Research and Analysis found that 67% of the children who were no longer enrolled in HUSKY A were insured for the most part (89%) by employer sponsored coverage with their parents who were also formerly enrolled themselves. Other reasons of why children were not re-enrolled were: Parents were unaware of what eligibility criteria were, parents did not know how long coverage extended and were unaware of the need to re-enroll every year. Participation in a government program was not perceived as a stigma among the former clients surveyed. Many of the families surveyed were unaware that their income levels and enrollment in commercial health plans did not totally close them out of receiving HUSKY A. HUSKY A could help pay for co-payments and deductibles and could help close gaps in coverage due to changes in employment.

2.6 **Coordination between SCHIP and Medicaid**:

1. Do you use common application and redetermination procedures (e.g. the same verification and interview requirements) for Medicaid and SCHIP? Please explain

   The Medicaid and SCHIP application forms are the same. However, during FFY 2000 the HUSKY application form was revised and also put into use for Medicaid renewals / redetermination beginning October, 2000. HUSKY B continues to use a pre-filled form for renewal of eligibility. Both programs use the HUSKY applications for new applicants.

2. Explain how children are transferred between Medicaid and SCHIP when a child's eligibility status changes.

Children are referred to the SCHIP program by the Medicaid program when the child is not eligible for Medicaid, either directly by the Department, or the client may initiate contact themselves after learning they are not eligible for Medicaid. Computer lists of individuals who are inactive in Medicaid spendown are used to refer clients to SCHIP. The Department's single point of entry, Benova, also screens applicants for eligibility and makes referrals. Children losing HUSKY B eligibility because of decreased income are referred to the Department of Social Services for Medicaid (HUSKY A) determination.

3. Are the same delivery systems (including provider networks) used in Medicaid and SCHIP? Please explain.

There are four managed care organizations under contract to DSS for Medicaid managed care. These are Anthem Blue Cross/Blue Shield, Community Health Network, First Choice Health Plan of Connecticut (Preferred One), and Physicians Health Services (PHS). Each of these plans participate in SCHIP (HUSKY B) except PHS. The provider networks are largely comparable. With the SCHIP (HUSKY B) there are two special provider network programs, the HUSKY Plus Physical (HPP) and HUSKY Plus Behavioral (HPB). HPP involves direct contracts between DSS and two Title V (Maternal and Child Health) designated hospitals who accept referrals from the HUSKY B plans and provider wrap-around services. There are slight variations in the provider networks between the three MCOs in the two HUSKY programs.

2.7 Cost Sharing:

1. Has your State undertaken any assessment of the effects of premiums/enrollment fees on participation in SCHIP? If so, what have you found ?

No study has been conducted yet. This will be incorporated in the HUSKY B External Quality Review of the plans. Preliminary disenrollment data suggests that some disenrollments are due to non-payment of premiums.

2. Has your State undertaken any assessment of the effects of cost-sharing on utilization of health service under SCHIP? If so, what have you found?

No study conducted yet. This will be incorporated in the HUSKY B External Quality Review of the plans.

2.8 Assessment and Monitoring of Quality of Care:

1. What information is currently available on the quality of care received by SCHIP enrollees? Please summarize results.

The Connecticut Department of Social Services currently has available to it several sources of information concerning quality of care received by SCHIP enrollees. The table below summarizes a few of the major information sources:

Program	Data Source	Type of Data	Results
HUSKY A (Medicaid)	MCOs through contractor	Encounter data	Problems with completeness but data are good enough for EQRO (Qualidigm) to use as input for quality audits and for Children's Health Council (CHC) to use in tracking EPSDT visits and other analyses
HUSKY A (Medicaid)	MCOs directly to department	Aggregate utilization reports	Reports are useful to Medicaid Managed Care Advisory Council in monitoring DSS's administration of program.
HUSKY A	MCOs directly	Aggregate utilization reports	Reports are useful to department in

(Medicaid) and HUSKY B (separate SCHIP)	to department		monitoring MCO performance & its impact on member access.
HUSKY A (Medicaid) and HUSKY B (separate SCHIP)	External Quality Review Organization (EQRO [Qualidigm])	Operational audits	Audits are useful to department in monitoring MCO operations and their impact on members.
HUSKY A (Medicaid)	Children's Health Council (CHC) contractor, Children's Health InfoLine (CHIL)	Reports of call center activity, case review meetings.	Reports on volume and types of calls received, plus case review meetings with department staff highlight and give early warning on impending access or quality issues.
HUSKY A (Medicaid)	DSS Appeals Tracking	Greivance / Fair Hearing Tracking Log and Reports.	Analysis allows department to monitor trends in client problems with access and quality.
HUSKY A (Medicaid)	Department of Public Health (DPH)	Reports on immunizations, blood lead level screens & birth certificate match.	Allows department to monitor delivery of immunizations, lead screens, and prenatal care.

2.What processes are you using to monitor and assess quality of care received by SCHIP enrollees, particularly with respect to well-baby care, well-child care, immunizations, mental health, substance abuse counseling and treatment and dental and vision care?

By contract and through monthly meetings with the managed care organizations (MCOs) the department has established a series of quarterly reports covering these very subjects.
In so far as is possible the methodology for each report is based on the National Committee for Quality Assurance (NCQA) Health Employer Data Information Set (HEDIS) specifications, thereby allowing the department to compare the SCHIP program against the benchmark of HEDIS reports for other states and commercial HMOs.

In addition, the CHC uses encounter data to monitor the timeliness of well child visits, including well baby care, and provides detailed feedback to MCOs concerning children who have not received well child visits on time. HUSKY MCOs are required to contract with the Connecticut DPH's Connecticut Immunization Registry and Tracking System (CIRTS). CIRTS provides a centralized means for HUSKY PCPs to report on the immunization status of children enrolled in the HUSKY Program. In turn, PCPs are able to query CIRTS regarding the immunization status of children new to their practice. Annually CIRTS reports aggregate immunization data to the MCOs and the department.

As a backstop and look behind to the above data sources for monitoring the quality of care received by SCHIP enrollees, the department has commissioned the EQRO to do focused studies of the content of well child visits, maternal and prenatal care, discharge planning in behavioral health, and to evaluate the HUSKY Plus Behavioral and Physical Health programs. The department works closely with the Bureau of Community Health in DPH to monitor access to dental care. The department is also carrying out a couple of initiatives with Yale University to monitor and assess outcomes of behavioral health treatment for children in HUSKY and the use of psychotropic medications by children in HUSKY.

During the past year, the department commissioned the CHC to conduct a consumer satisfaction survey of children with special health care needs as defined by the Balanced Budget Act. In addition, HUSKY MCOs conducted consumer surveys of their HUSKY members as required by their contracts with the department. In both cases, the surveys are based on the Consumer Assessment of Health Plans Survey (CAHPS), thereby allowing for benchmarking to surveys in other states.

3. What plans does your SCHIP program have for future monitoring/assessment of quality of care received by SCHIP enrollees? When will data be available?

The Department plans to continue its current activities as described above for monitoring and assessment of the quality of care received by SCHIP enrollees. New initiatives include a match of HUSKY enrollment with birth certificates for the purpose of assessing prenatal care and birth outcomes, reporting on access and quality of care provided to children with special health care needs as required by the department's waiver under section 1915(b) of the Social Security Act, and working with the DPH to improve the ability of DPH's immunization, blood lead level screening, vital records, WIC, and Title V data bases to interface with data contained within the HUSKY Program for the purposes of better monitoring and tracking the quality of care received by HUSKY Program members. If all goes well, the department expects to have data from these initiatives available by the end of the year.

SECTION 3. SUCCESSES AND BARRIERS

This section has been designed to allow you to report on successes in program design, planning, and implementation of your State plan, to identify barriers to program development and implementation, and to describe your approach to overcoming these barriers.

3.1 Please highlight successes and barriers you encountered during FFY 2000 in the following areas. Please report the approaches used to overcome barriers. Be as detailed and specific as possible.
Note: If there is nothing to highlight as a success or barrier, Please enter "NA" for not applicable.

1. Eligibility
   - Positive aspects of HUSKY eligibility :
   - 12 months of continuous eligibility even if the family income increases during the year.
   - Simplified eligibility criteria, for example, no asset limit
   - Simplified verification limited to income and immigration status for the separate SCHIP.
   - Medicaid also requires verification of residency

   Barriers related to eligibility include unwillingness by some to provide verifiaction of family income and misunderstandings regarding immigration status on eligibility.

2. Outreach

   Public outreach activities for Connecticut's HUSKY Plan continued to generate significant numbers of hot-line calls and applications during FFY 2000. Applications on behalf of 53,399 children had been received by the single point of entry servicer,Benova Inc., from the opening of the combined Medicaid-SCHIP program in mid-1998 to the end of September, 2000.

   Representative results of outreach activity for the final quarter of FFY 2000 include:
   - 5,300 hotline calls to HUSKY Health Infoline;
   - 7,200 applications to the single point of entry servicer;
   - 4,700 hits on HUSKY website, www.huskyhealth.com, between 4/19/00 and 9/30/00.

   The majority of applications received since mid-1998 were referred to Department of Social Services offices for HUSKY A (Medicaid) eligibility determination (32,927 of 53,399). This indicates SCHIP's huge impact on getting parents to apply for children who were previously eligible for Medicaid but not served. SCHIP has enabled the public outreach, customer service initiatives like toll-free hotlines and friendly application gateway for the combined program.

3. Enrollment

   Connecticut's initiatives to increase enrollment, beginning or ongoing in FFY 2000, include:

- Integrating community-based outreach with ongoing health services ($4 million Connecticut Community Healthcare Initiative);
- Continuing emphasis on HUSKY as a service for working families of all income levels;
- Plans to continue media campaign that includes Governor's TV spot; ongoing radio and print ads concentrated in media serving African-American and Hispanic-Latino communities;
- Building on outreach through schools, athletic programs, pediatrician offices, and other mainstream sites serving children and families.
- Beginning "presumptive eligibility" to speed initial enrollment of children in Medicaid by enabling school-based health centers, WIC, Head Start sites and other qualified community programs.
- Streamlining enrollment within the program (further and coordination between HUSKY A and B components);
- Communications to reach families whose children formerly were in HUSKY A but who are not now in HUSKY B;
- Further simplifying application and enrollment for new members;
- Participation in the federal Health Resources and Services Administration's 'CompCare' technical assistance program to evaluate contracted outreach programs and track application trends by geographical and demographic criteria.

In the area of barriers, reasons identified for less new enrollment in SCHIP than in Medicaid, in Connecticut as across the nation, have included:

- Government stigma;
- Cost-sharing by parents;
- Lack of payroll deduction for premiums;
- Strength of the economy and the fact that most children, especially in the higher-income families potentially eligible for SCHIP, already have health insurance;
- 'Crowd out' waiting periods;
- Relative newness of the program;
- Misconception that public health coverage is a 'welfare' program and that it is only available for children of certain family incomes.
- Connecticut's comparatively high income-eligibility ceiling for Medicaid, which means that many children here go into Medicaid, when they would be entering SCHIP in other states.

Outreach approaches to overcome barriers include emphasis on messages communicating the importance of obtaining good health care for children; emphasis on HUSKY as a service for working families of all income levels (including buy-in option for over 300% of FPL); emphasis to outreach contractors that HUSKY should be marketed and communicated about as a general health coverage service, rather than a Medicaid or SCHIP service; continued policy of conducting outreach in a wide variety of venues and audiences. Toward this end, a sample of outreach initiatives follows:

- CT Coaches' Campaign for HUSKY Healthcare, in partnership with CT Interscholastic Athletic Association. New pamphlets, other materials in pilot distribution to 12 school systems chosen by CIAC. Target audience is school athletic directors and coaches as key informants to student-athletes and their parents about availability of health coverage. Plans to expand campaign.

- Community-Technical College outreach project, in partnership with Chancellor's Office and deans of students in individual community-technical colleges. Distribution of materials, training, presentations mainly targeting adult students with children.

- Nursing facility outreach, in partnership with Connecticut Association of Health Care Facilities. Presentations to human resource administrators and staff about availability of HUSKY. Many nursing facilities are not able to provide health insurance benefits for children of employees.

- School Lunch Application Project, in partnership with Department of Education and local school food service administrators. HUSKY notice in school lunch applications has resulted in over 3,000 parents returning form to get further information; additional parents calling hotline.

- Connecticut Medical Outreach Project, in partnership with CT Chapter of American Academy of Pediatrics. Professional outreach to pediatrician and family practice offices about availability of HUSKY coverage.

4. Retention/disenrollment

Continuous Eligibility is a positive feature of the HUSKY program which contributes to the retention of coverage for children. On average about 8,000 additional children are provided Medicaid coverage resulting from CE. A barrier related to retention is the transitioning of children who gain income from Medicaid to the separate SCHIP programs. The reasons for this is that there are two separate I.S. systems interfacing and the reason for Medicaid closure is not always captured and these clients can not always be identified. The largest number of losses occur at the time of annual renewal . Many families do not return the renewal form or do not provide income verification. Funding obtained from a Robert Woods Johnson grant this year will support a study focusing on the reasons for families not renewing eligibility and being retained in the program.

5. Benefit structure

Connecticut designed a generous package of services for its managed care basic benefits while providing for additional or "wrap around" services for children with physical or behavioral health needs through the HUSKY Plus programs. However, enrollment in HUSKY Plus has been lower than expected. We believe that a rich basic benefit package and a comparatively healthy population among the HUSKY B children accounts for this low enrollment.

6. Cost-sharing

There is evidence that premium cost sharing by the family may act as a barrier for some families. On average, there are 400 children per month who, although eligible for the separate SCHIP program, are not enrolled in a health plan due to non-payment of premiums.

7. Delivery systems **NOT APPLICABLE**

8. Coordination with other programs

9. Crowd-out **NOT APPLICABLE**

10. Other

SECTION 4. PROGRAM FINANCING

This section has been designed to collect program costs and anticipated expenditures.

4.1 Please complete Table 4.1 to provide your budget for FFY 2000, your current fiscal year budget, and FFY 2002 projected budget. Please describe in narrative any details of your planned use of funds.

Note: Federal Fiscal Year 2000 starts 10/1/99 and ends 9/30/00).

	Federal Fiscal Year 2000 Costs	Federal Fiscal Year 2001 Costs	Federal Fiscal Year 2002 Costs
Benefit Costs			
Insurance Payments			
Managed Care [1]	7,982,867	14,095,707	19,178,346
per member/per month rate x # of eligibles	61,218	99,726	139,036
Fee for Service	-	-	-
Total Benefit Cost	**7,982,867**	**14,095,707**	**19,178,346**
Administrative Costs			
Personnel	720,311	763,340	781,833
General Administration	77,843	82,493	84,491
Contractors/Brokers [2]	290,531	307,886	315,345
Claims Processing [3]	28,420	30,118	30,848
Outreach/Marketing [4]	846,141	896,686	918,410
Other	-	-	-
Total Administration Cost [5]	**1,963,246**	**2,080,523**	**2,130,927**
10% Administrative Cost Ceiling	1,963,246	3,222,483	2,130,927
Federal Share	1,276,110	2,094,614	1,385,103
State Share	687,136	1,127,869	745,825
TOTAL PROGRAM COST	**9,946,113** [6]	**16,176,230** [6]	**21,309,273**

[1] Includes HUSKY B and HUSKY Plus programs. Does not include MCHIP expenditures.
[2] Prorated portion of actual and estimated expenditures for Benova (enrollment broker).
[3] Prorated portion of MMIS claim processing costs.
[4] FY 2001 and FY 2002 are estimated based on prorated projection of SFY 2001 and SFY 2002 expenditures.
[5] Represents actual dollars claimed in FFY 2000 and estimated claim up to 10% administrative cap in
FFY 2001 - 2002. Dollars are consistant with 10% administrative costs under CHIP.
[6] Does not include MCHIP expenditures.
Not available at this time.
[7] Reflects end of MCHIP program in October 2001.

4.2 Please identify the total State expenditures for family coverage during Federal fiscal year 2000
. No family coverage was provided during this period.

4.3 What were the non-Federal sources of funds spent on your CHIP program during FFY 2000?

_X__ State appropriations
_____ County/local funds
_____ Employer contributions
_____ Foundation grants
_____ Private donations (such as United Way, sponsorship)
_____ Other (specify)

A. Do you anticipate any changes in the sources of the non-Federal share of plan expenditures.
No.

SECTION 5: SCHIP PROGRAM AT-A-GLANCE

This section has been designed to give the reader of your annual report some context and a quick glimpse of your SCHIP program.

5.1 To provide a summary at-a-glance of your SCHIP program characteristics, please provide the following information. If you do not have a particular policy in-place and would like to comment why, please do. (Please report on initial application process/rules)

Table 5.1	**Medicaid Expansion SCHIP program**	**Separate SCHIP program**
Program Name		
Provides presumptive eligibility for children	___X__No, for FFY 2000; implemented 10/2000 Yes, for whom and how long?	__X___No _____Yes, for whom and how long?
Provides retroactive eligibility	_____No ___X___Yes, for whom and how long? Up to 3 months	___X___No _____Yes, for whom and how long?
Makes eligibility determination	___X__State Medicaid eligibility staff _____Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*	_____State Medicaid eligibility staff ___X__Contractor _____Community-based organizations _____Insurance agents _____MCO staff _____Other *(specify)*
Average length of stay on program	Specify months ___Not available at this time.	Specify months __Not available at this time
Has joint application for Medicaid and SCHIP	_____No ____X_Yes	_____No ____X_Yes
Has a mail-in application	_____No ___X___Yes	_____No ___X___Yes

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
Can apply for program over phone	No	____ No ___X__Yes, but pre printed application has to be returned with signature
Can apply for program over internet	___X__No, but application can be printed off the internet _____Yes	___X__No, but application can be printed off the internet. _____Yes
Requires face-to-face interview during initial application	___X__No _____Yes	___X__No _____Yes
Requires child to be uninsured for a minimum amount of time prior to enrollment	__X___No _____Yes, specify number of months What exemptions do you provide?	_____No. __X____Yes, specify number of months __6__, but only if insurance was employer-sponsored. What exemptions do you provide? Loss of employment, financial hardship, private insurance
Provides period of continuous coverage <u>regardless of income changes</u>	_____No __X__ Yes, specify number of months __12 Explain circumstances when a child would lose eligibility during the time period. Move out of state, turn 19, or death	_____No X_____Yes, specify number of months __12 Explain circumstances when a child would lose eligibility during the time period. Move out of state, turn 19, death, become Medicaid eligibie
Imposes premiums or enrollment fees	__X___No _____Yes, how much? Who Can Pay? ___ Employer ___ Family ___ Absent parent ___ Private donations/sponsorship ___ Other (specify)	_____No ___X_Yes, how much? __3 income bands depending on income Under 235% FPL, no premium; 235% to 300% FPL, $30 for one child, $50 2 or more children; over 300% FPL, full buy-in. Who Can Pay? ___ Employer __X_ Family _ X__ Absent parent, if application is filed by the non-custodial parent.

Table 5.1	Medicaid Expansion SCHIP program	Separate SCHIP program
		___ Private donations/sponsorship ___ Other (specify)
Imposes copayments or coinsurance	__X___No _____Yes	_____No ___X_Yes
Provides preprinted redetermination process	__X___ No _____ Yes, we send out form to family with their information precompleted and: ___ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed	_____ No __X___ Yes, we send out form to family with their information and: __X_ ask for a signed confirmation that information is still correct ___ do not request response unless income or other circumstances have changed

5.2 Please explain how the redetermination process differs from the initial application process.

For HUSKY B clients receive a pre-printed form for review, updating and income verification. Prior to October 2000, HUSKY A clients received a Medicaid form from DSS. As of October, 2000, the new four page HUSKY application/renewal form is used.

SECTION 6: INCOME ELIGIBILITY

This section is designed to capture income eligibility information for your SCHIP program.

6.1 As of September 30, 2000, what was the income standard or threshold, as a percentage of the Federal poverty level, for countable income for each group? If the threshold varies by the child's age (or date of birth), then report each threshold for each age group separately. Please report the threshold after application of income disregards.

Title XIX Child Poverty-related Groups or Section 1931-whichever category is higher	_185% of FPL for children under age <19 years old ____% of FPL for children aged ____% of FPL for children aged
Medicaid SCHIP Expansion	185% of FPL for children aged <19 years old ___% of FPL for children aged _____ ____% of FPL for children aged _____
State-Designed SCHIP Program	186-300 % of FPL for children aged <19 ____% of FPL for children aged _____ ____% of FPL for children aged _____

6.2 As of September 30, 2000, what types and *amounts* of disregards and deductions does each program use to arrive at total countable income? *Please indicate the amount of disregard or deduction used when determining eligibility for each program. If not applicable, enter ANA.@*

Do rules differ for applicants and recipients (or between initial enrollment and redetermination) ____
Yes ___ X_No
If yes, please report rules for applicants (initial enrollment).

Table 6.2

	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Earnings	$90/month	$90/month	$90/month
Self-employment expenses	Business related exp.	Business related exp.	Business related exp.
Alimony payments Received	$0	$0	$0
Paid	$0	$0	$0
Child support payments Received	$100/month	$100/month	$100/month
Child Support payments Paid	$0	$0	$0
Day care expenses Out of pocket up to $200/ month, less than 2 years old; above 2yrs. Or adult, $175/ month	$see note in previous box	$same	$same
Medical care expenses	$0	$0	$0

Table 6.2			
	Title XIX Child Poverty-related Groups	Medicaid SCHIP Expansion	State-designed SCHIP Program
Gifts up to $30/ calendar quarter	$	$	$
Other types of disregards/deductions (specify)	$	$	$

6.3 For each program, do you use an asset test?

Title XIX Poverty-related Groups __X__No ____Yes, specify countable or allowable level of asset test_____

Medicaid SCHIP Expansion program __X__No ____Yes, specify countable or allowable level of asset test_____

State-Designed SCHIP program ___X_No ____Yes, specify countable or allowable level of asset test_____

Other SCHIP program_____NA_____ ____No____Yes, specify countable or allowable level of asset test_____

6.4 Have any of the eligibility rules changed since September 30, 2000? __X_ Yes ___ No

SECTION 7: FUTURE PROGRAM CHANGES

This section has been designed to allow you to share recent or anticipated changes in your SCHIP program.

7.1 What changes have you made or are planning to make in your SCHIP program during FFY 2001(10/1/00 through 9/30/01)? Please comment on why the changes are planned.

1. Family coverage
   On January 1, 2001 Medicaid coverage was extended to adult caretakers of children in Medicaid with incomes of < 150% FPL.

2. Employer sponsored insurance buy-in.

3. 1115 waiver
Currently exploring the expansion of SCHIP to parents of HUSKY eligible children who work in home healthcare, childcare, skilled nursing settings and who do not have insurance through their employer.

4 .Eligibility including presumptive and continuous eligibility

5.Outreach
   The Connecticut Community Healthcare Initiative is consolidating community-based outreach with the Healthy Start program for prenatal care/case management. Other new and planned outreach measures are described in Sections 1, 2 and 3.

Enrollment/redetermination process.
   Pre- printed renewal forms for HUSKY A , estimated to be introduced April, 2001.

Contracting
   Possible carve-out of behavioral health and dental services.

Other